

General

Guideline Title

Bathing persons with dementia.

Bibliographic Source(s)

Hall GR, Gallagher M, Hoffmann-Snyder C. Bathing persons with dementia. Iowa City (IA): University of Iowa College of Nursing, John A. Hartford Foundation Center of Geriatric Nursing Excellence; 2013. 58 p. [51 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Thiru-Chelvam B. Bathing persons with dementia. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2004. 37 p.

Recommendations

Major Recommendations

Note from the University of Iowa College of Nursing, John A. Hartford Foundation Center of Geriatric Nursing Excellence and National Guideline Clearinghouse (NGC): In addition to the following recommendations, the guideline developer also provides Key Points in the full-text guideline document.

The grades of evidence (A1-D) are defined at the end of the "Major Recommendations" field.

Assessment

Every person entering a long-term care setting should be formally assessed for cognitive and functional status. In addition, when an applicant has a dementing illness, the staff has to gain information from multiple sources including the person being admitted, the family, primary care provider (PCP), and institution, such as a hospital or nursing home transferring the applicant. The goal of assessment is to know, as clear as possible, the person's abilities and need for assistance in order to provide quality person-centered care.

History and Physical

While a medical history and physical are the first pieces of information needed by caregivers, in many unregulated settings these are not collected. In facilities where nurses provide, supervise, or consult on care, a person's history and physical are essential data when planning care.

Functional Assessment

Functional assessments usually provide information regarding the person's need for help with a particular activity of daily living (ADL) and the level

of assistance needed to "get the job done." They are the initial indication of patient needs; however, additional information is required to make the bath person-centered.

While there are numerous functional assessments available, two of the oldest and simplest, Barthel's Index and Index of ADL, work well in clinical practice settings. Physical functioning focuses on basic ADLs including feeding, bathing, dressing, mobility, and toileting (Evidence Grade = A2). Assessment of instrumental (or intermediate) activities of daily living (IADLs) addresses more advanced self-care activities, such as shopping, cooking, and managing finances and medications.

1. Standardized assessment instruments such as the Barthel's Index (Evidence Grade = A2) can provide information on the patient's capacity for self-care and independent living. Proxies or patient surrogates can complete these instruments when necessary (Evidence Grade = B1).
2. The Index of ADL (Evidence Grade = A2) is a brief assessment of six basic activities and how much supervision/assistance is needed to accomplish the daily tasks. Although the instrument was developed in the early 1960s, it has become "the gold standard" for clinical practice (Evidence Grade = B1). One advantage to the Index of ADL (Evidence Grade = A2) is that it can be used by providers who are not nurses. Many people with dementia are now admitted to assisted living facilities or group homes where access to nurses is limited – often to just consulting visits – or there is no nurse at all.

For those working in nursing facilities, the functional assessment on the Minimum Data Set can be used as the ongoing functional assessment for care planning. On admission or before a person with dementia enters a care facility, the initial interviews between the care staff and the family are very important in establishing a successful path of appropriate care. It is also important to recognize that family reports may or may not be valid if the care recipient has not been living with the family members being interviewed. Family members often under-report actual functional level for a variety of reasons: 1) families often do not understand that refusing to bathe represents dependency; 2) the family may assume independence because the person has been living alone; 3) the family may be trying to qualify the person for a less expensive or more "socially acceptable" level of care; or 4) the family may suffer embarrassment over the person's lack of personal care. Moreover, people with dementia tend to insist they are independent in most ADLs, making it difficult to confirm what the family has reported.

Knowledge of the individual's history of bathing practices and preferences would assist in determining the time of day (morning or later in the day) and the type of bathing process (tub, shower or bed bath) to be used initially for that person (Evidence Grade = B1). Ask direct caregivers if there are any issues with bathing such as resistance or agitation, and what measures they use to prompt bathing, such as "cleaning up" before an activity.

Cognitive Assessment

The primary reasons to administer a brief cognitive test include developing an understanding of the severity of the cognitive decline, to help comprehend the visuospatial perception and to identify or confirm residual abilities in the person that can be maximized to promote their active participation in care. Re-administration of these cognitive tests to measure changes over time or sudden cognitive alteration such as the onset of delirium should be done every six months or if there is a sudden change in mental status. The use of simple well-accepted cognitive screens also assists staff when communicating with other health providers in reporting the person's status. Numerical scores help providers determine where the person is in their disease process and therefore anticipate their need for assistance with personal care, including the individual's ability to participate in, or even accept the bathing process. While there are many tools available, some can be performed by nurses and others would need the input of other professionals. An occupational therapist is a good resource when looking at cognitive and functional status testing.

Some examples of tests are:

- The Mini Mental State Examination (MMSE) – A 30 question test easily administered by nurses and non-professional caregivers, the MMSE is the current "gold standard," because of its universal use. There are some drawbacks to its use as a screen, especially in non-Alzheimer-type dementias where the MMSE does not evaluate the impaired areas of the brain in frontotemporal dementia (FTD) or symptoms that alternate between severe and mild such as dementia with Lewy bodies (DLB).
- Clock Drawing – Providers give the person a blank sheet of paper, asking them to draw a clock face and set the hands at 11:10. The clock draw is a valuable tool to determine verbal understanding, memory, and visuospatial perception.
- The Montreal Cognitive Assessment (MOCA), a newer mental status assessment that is more sensitive for early Alzheimer's disease (AD) and FTD, is a 30 question test easily administered by professionals or non-professionals (Evidence Grade = A2). It includes questions found on the MMSE, a clock draw, and "Trails A & B," a test sensitive in determining executive dysfunction (inability to plan, initiate, and sequence activities to meet a goal such as putting on shoes and socks). Easy to administer and score the MOCA is available online at <http://www.mocatest.org/> .

Behavioral Assessment

"In an observational study of people with dementia more than 90% became agitated as soon as they were told it was time to bathe" (Evidence Grade = D). Facility staff needs to know the new applicant's behavioral issues:

- What does the person do when they become upset or fatigued? How often does this occur? What do the behaviors entail and how intense are they? How long do the behaviors last? What time of day are they likely to occur? Are the behaviors triggered by anything? What do you do to avoid or resolve them?
- How often does the person bathe? What time of day? Is there anything in the past that might affect frequency of bathing (such as growing up without indoor plumbing)? How does the person bathe now (tub, shower, at sink, only with prompting)? Does the person use any special products, robes, towels, or equipment during bathing (bubble bath, scented soaps, music, back brush, or sponge) to make the experience more enjoyable? Is the person especially modest?

This assessment should be used in making the plan of care more person-centered and consulted when modifications to the bathing plan are needed.

Behavior monitoring can be achieved through observing and recording the person's response in certain situations and using the patient record for a historical perspective of behaviors. If the bathing method established is accepted by the individual it should be documented so that other caregivers will follow the same routine. If it is not accepted, then further explorations into alternative approaches are necessary until a bathing process is found which is accepted by the individual.

Every attempt should be made to avoid bathing people against their will. Assessment is the only way to gather enough information about the person in order to individualize care and provide person-centered care.

Description of Practice

The Bathing Process

Bathing people with dementia is a complicated process of applying physical, emotional, and environmental factors to the care recipient's best advantage in order to promote a safe, acceptable, and comfortable method for cleansing the person's skin. Bathing should never be forced on a person or treated as a life or death, win/lose situation. Careful documentation of methods and outcomes will assist future caregivers in providing appropriate accepted practice to individual care recipients.

Because of the complexity of the bathing activity, this section will be divided into subheadings, moving the reader through the entire bathing process:

- Why Reactions Occur gives insight on the reasons behind the individual's response to what they are experiencing before, during, and after the bath.
- Caregiver Approach explains the ways a skilled caregiver can make a difference in how the individual responds to the bathing process.
- Preparation for the Bath takes the caregiver through a number of considerations to set up a positive experience for both the individual and the caregiver.
- The Bath gives points on the process and important facts that should be kept in mind while bathing an individual.
- After the Bath explains why an assessment of the outcome is necessary.
- Environmental Considerations will give a number of ideas which can be incorporated or modified to fit into most care facilities.
- Administrative/System Concerns discusses issues related to facility administration and/or regulatory issues that affect the implementation of evidence-based practice for bathing.

Why Reactions Occur

- Bathing involves multiple stressors and persons with dementia have a decreased threshold for tolerating stress in their environment (Evidence Grade = D).
- Being undressed and washed by a stranger may be a humiliating, frightening, and potentially traumatic experience (Evidence Grade = D).
- Agitated behaviors are more likely to occur with providing care in two ADLs, feeding and bathing. Negative verbal responses were more likely to be treated with benzodiazepines and neuroleptic medications (antipsychotics). Both have limited efficacy and pose risk to the residents (Evidence Grade = B2). Showering an individual with dementia was the ADL most likely to provoke patient to staff physical aggression (Evidence Grade = C/B2).
- Self-protective behaviors are normal responses to the following perceived threats:
 - Unfamiliar activities
 - The presence of strangers
 - Unpleasant sensations – cold, pain
 - Fear of catching cold
 - Feeling confused, dominated, insulted
 - Misinterpretation as a sexual assault

- Impaired ability to recognize staff as being helpful not harmful
- Unwanted touch or invasion of personal space
- Frustration from declining abilities
- Anticipation of pain
- Perceived loss of control
- Lack of attention to personal needs (Evidence Grade = A1/D)
- ADLs, including bathing are not improved with the addition of a cholinesterase inhibitor, however they do delay additional functional decline (Evidence = B1).
- Caregivers report the most common physical aggression from bathing includes hitting, punching, and slapping followed by pinching and pushing. The most common needs the resident has during bathing are control and an absence of cold, pain, and fear (Evidence Grade = D).

Caregiver Approach

Many caregivers possess intuitive skills which assist them in understanding and caring for persons with dementia. There are however, many skills that can be learned by staff motivated to providing quality care to all individuals who may require assistance in performing ADLs.

- When bathing is seen as a treatment it carries the same compelling necessity as a medication order. Caregivers feel pressured to carry out the order with little discretion (Evidence Grade = D). As a result, the bathing process may continue on a regular basis without either the resident or the caregiver achieving a positive experience.
- There is a positive correlation between increased activities of care and caregiver burden, including direct tasks such as bathing (Evidence Grade = C1).
- Training certified nursing assistants (CNAs) in person-centered care, including material on gentleness and verbal support was tested in residents who experienced agitation and aggression while bathing. By using gentleness and verbal support, behaviors improved during both types of bathing and changed the CNAs perception of bathing activities (Evidence Grade = A2).
- Nursing practice rituals such as bathing need to be rethought in terms of who really benefits from this activity. The need to put the individual's needs first and adjust nursing care to them via individualized approaches cannot be over emphasized (Evidence Grade = D).
- Shifting the caregiver's perspective from task-focused to person-focused is one way to change the psychosocial environment in which a successful bathing process can occur (Evidence Grade = C).
- In a study of antecedents to assaultive behavior during bathing, researchers found that caregiver behavior, especially five seconds prior to the assault triggered the behavior. Caregiver behaviors included calling the resident by name; confrontational communication; invalidation of the resident's feelings; absence of personal restraint; spraying water without telling the individual; touching feet, axilla, or perineal area; non-bath related communications; and failing to prepare the resident for the bath. Additional training and less invasive bathing measures are recommended (Evidence Grade = A2).
- Understanding the individual and their behavior is crucial for staff to be able to provide safe care and prevent aggression (Evidence Grade = C).
- Knowledgeable caregivers will preserve the dignity of the individual by shifting the focus from tasks of bathing to needs and abilities of the person being bathed with emphasis on comfort, safety, autonomy, and self-esteem (Evidence Grade = D).
- The following are additional strategies for defusing resident resistance and gaining participation in bathing:
 - Giving choices
 - Knowing personal preferences (i.e., time, day, type of bath)
 - Allowing for privacy
 - Providing same gender caregiver if possible
 - Keeping directions simple, one step, to reduce the amount of stimuli
 - Adjusting the bathing schedule to meet individual's preferences
 - Giving adequate time for the bath so the person does not feel hurried
 - Encouraging use of the person's abilities whenever possible (Evidence Grade = A1)
- Knowledgeable caregivers need to display the following skills:
 - Patience
 - Flexibility
 - Sensitivity
 - Gentleness
 - Creativity
 - A genuine interest in older persons (Evidence Grade = A1/D)

Preparing for the Bath

Time spent preparing both the individual and the environment for the bathing process could have a very positive effect on the final outcome (see Appendix B in the original guideline document: Helpful Communication Techniques). Only by listening to, carefully observing the individual, and by speaking with family members can the individual's expectations and perceptions of bathing be appreciated (Evidence Grade = A1).

- By interviewing the family members and discovering the past personal habits of each individual, the nurse has a framework for how to approach the individual in terms of which bathing methods are acceptable for each person. For example, the caregiver should not expect that an elderly woman who always bathed at the sink would respond favorably to a tub or shower bath (see Appendix A in the original guideline document: Bathing Option Decision Tree) (Evidence Grade = C1).
- Individualized bathing care plans should be developed from the perspective of the person to be bathed, including goals for the bath, outcomes to achieve and background information which may provide extra help in achieving the goals (Evidence Grade = D).
- Goals can be developed in relation to identifying the specific function the bath is to serve, the frequency needed and what form can be used to achieve that function (Evidence Grade = C).
- In considering form, look beyond a tub or shower to include the possibility of a bed bath (Evidence Grade = C) (see Appendix C: Procedure for Thermal Bathing Method and Appendix D: Towel or Bed Baths in the original guideline document).
- Create a list of reasons the caregivers can use to explain to the individual why they should bathe. For example, the following are a few "approach" techniques to use in gaining the person's cooperation:
 - Preparing for the day
 - A special occasion
 - To get ready for a meal-breakfast, lunch
 - They have worked hard and need to "freshen up" (Evidence Grade = D)
- Use persuasion, not coercion. Do not pressure the person. This will increase agitation. Allow the person to remain in control (Evidence Grade = A1/D).
- If undressing in either the bedroom or the bathroom and resistance occurs, give the person a reason to remove their clothes (e.g., laundry day today) (Evidence Grade = D).
- Ensure privacy by closing the door and not undressing until absolutely necessary (Evidence Grade = C2). Always try to minimize the time the person is unclothed (Evidence Grade = D).
- Avoid a series of distasteful tasks in succession. If undressing agitates, bathe in the morning when one only needs to remove pajamas or nightgown, or undress only a little at a time, such as keeping the shirt on while washing the legs, covering the lower body when removing trousers (Evidence Grade A1/D).
- How the person is transported to the bathing area is also important. A negative response here will set the tone for the rest of the bathing process. If transporting in a shower chair is uncomfortable use a wheelchair or if able, allow to walk. Make sure the patient is kept warm and well covered on the way to the bathing area. (Evidence Grade = D).
- Be sure the bathing area is prepared before the individual arrives. Keep everything warm, including the room, water, towels, and blankets (Evidence Grade = D).
- The person's perceptions are always valid – cold is cold, pain is pain. Stay attuned to responses and validate their experiences (Evidence Grade = A1/D).
- Help the individual understand by:
 - Reminding
 - Redirecting
 - Making eye contact
 - Using comforting words, touch
 - Negotiating/offering rewards such as food during or after the bath, playing music during the bath, or negotiating having the bath at a different time (Evidence Grade = D)
- If it is determined that bathing causes or increases pain, appropriate medications to control that pain should be given 30-40 minutes before the bath begins (Evidence Grade = D).
- Stretch and stimulation of muscles can trigger a response often interpreted by the caregiver as resistance. Slow and steady movement can sometimes overcome this problem (Evidence Grade = D).
- Try bubble bath or color water using bath salts or for those who may fear water or cannot visualize water in the tub (Evidence Grade = D).

The Bath

Whether it is performed in a tub, a shower, at a sink, or in bed there are a number of principles and guidelines to follow in each situation for the process to be pleasant and therapeutic.

- Reviews of outcomes of past interventions using the Treatment Routes for Exploring Agitation (TREA) approach for non-pharmacological treatment of agitation in people with dementia (PWD) presents the preliminary findings to improve the process of bathing in PWD. The

discussion reviews the four major factors that contribute to agitation in PWD during bathing: 1) PWD's needs; 2) caregiver needs; 3) the physical environment of the bathing area; and 4) institutional factors. The operational framework is based on the Unmet Needs and TREA models.

- Researchers noted positive behaviors when an interventional care practice model was used including: five sessions of in-class training; staff support; resources needed to complete the intervention (i.e., soft towels); interventions to address unmet resident needs; environmental measures; and informed consent. The protocol resulted in increased knowledge and understanding of the resident and factors required to create a favorable bathing experience. The duration of bath time initially lengthened as new bathing techniques were implemented, but over time, the duration was comparable to pre-intervention bath times. The staff needs to feel educated, supported, and provided with all the necessary materials to achieve success. Research assistants observed a reduction for pre-and post-scores in agitated behaviors ($p < .001$ for t-tests on anger, physical agitation, physical aggression, total agitation, and interest). Reductions in verbal agitation approached significance ($p = 0.8$) (Evidence = A2).
- An evaluation of a restorative care model, Res-Care, used CNA training with oversight from an advanced practice nurse to help residents engage in both functional and physical activities including bathing. Sixty percent (60%) of residents were unable or unwilling to stand or ambulate at the start of the study. At the end of four months significant improvements were seen in the level of self-efficacy with bathing (Evidence Grade = A2).
- A randomized clinical control trial comparing person-centered showering and towel baths studied 73 residents with histories of agitation while bathing. Measures of agitation, aggression, and discomfort declined significantly in both groups, although the towel bath was significantly more comfortable than the shower. The length of bathing activity with showering increased by 3.3 minutes but did not increase for the towel bath. Skin condition improved equally with both methods. Thus, while there are advantages to the towel bath and person-centered shower, the towel bath was the least time consuming and uncomfortable. (Evidence Grade = A2).
- Rushed, task-orientated behavior by the caregiver was associated with agitated behavior by the individual. Avoid rushing. Use persuasion and allow the person to feel they are in control. Encourage participation whenever possible (Evidence Grade = D).
- Speaking in a low pleasant voice, giving information before and all through the bathing process is a strategy that can help to keep the person calm and in control. Give repeated reassurance that the person is safe and not alone (Evidence Grade: D/C).
- Calm behaviors from the individual have been shown to be the result of engaged verbal communication from the caregiver (Evidence Grade = C/D). If agitation occurs, use distraction, bring up a pleasant topic (Evidence Grade = C) or use other distraction such as music, singing, holding an object, or eating (Evidence Grade = D).
- Focus on an awareness of how the person is responding, including if the timing of the bath was appropriate (Evidence Grade = D/C).
- Concentrate on the person's feelings and reactions. Pay attention and don't converse with others, listen to the radio or daydream (Evidence Grade = A1). In addition, watch for warning signs. Stay alert to non-verbal behaviors such as facial expressions, mood, or raising fists (Evidence Grade = C/D). If agitation escalates, modify the plan and give a partial bath or delay hygiene altogether. There is always tomorrow (Evidence Grade = C). Always acknowledge the person's request to stop (Evidence Grade = D).
- Use "rescuing" if necessary to reduce agitation. A negative response to one caregiver can be "solved" by the second caregiver. However, two people should not bathe different parts of the person. Keep stimulation singular and focused (Evidence Grade = C).
- Resistance may be due to anxiety, trouble initiating or coordinating movements or both, fear of falling or physical pain. When moving into tub or shower, break the steps into small simple directions. Accompany verbal prompting with touch – a gentle pressure on the leg that should move first or behind the knees to sit (Evidence Grade = D).
- Recognize and validate expressions of pain. Pain could be due to arthritis or other physical problems (Evidence Grade = D). Painful feet should be handled gently and tender areas of the body patted dry not rubbed. A thin towel or Q-tip can be used to dry between toes (Evidence Grade = D). When pain cannot be successfully treated to withstand movement into the tub or shower, the person should be bathed in bed (Evidence Grade = D).
- See Appendices D and E in the original guideline document: Thermal and Towel Bathing Methods.
- If washing the hair during the bath creates a negative response try an alternative approach. Use a soapy washcloth and tilt the head back always keeping the soap out of the eyes. Wet hair can be very cold. Try washing hair last and cover immediately with a towel. Hair can also be done at a separate time with an inflatable basin in bed or non-rinse shampoos which is rubbed in and towel dried (Evidence Grade = D). A visit to the beauty parlor can elicit pleasant memories for some elderly ladies (Evidence Grade = A1).
- To reduce the incidence of screaming, try reducing the stimulation, such as one caregiver instead of several, move slowly and minimize glare and noise. Try calm music, pleasing aroma, food, conversation, or song, and neck or shoulder massage to determine if these are helpful (Evidence Grade = D).
- Aggressive behaviors such as hitting, punching, and shoving can often be prevented if the early signs of agitation are observed and the caregiver backs off for a few minutes until the person calms (Evidence Grade = D).
- If an individual grabs at objects or people, distraction is often an effective technique. Give an object to hold, a towel or bath toy. Grabbing during transfer usually indicates a fear of falling. Constant reassurance is necessary. Guide the person's hand to the grab bar or edge of tub (Evidence Grade = D).

- In one study, findings suggest using music to enhance the bathing experience and decrease stress for PWDs and caregivers (Evidence = A2).
- Individuals who are at risk for biting should have dentures removed if this is possible. Caregivers need to be aware of the person's mouth and keep a distance. If biting occurs during a transfer caregiver could wear a jacket. Offer something to keep in the mouth, such as gum, cookies or other food, or try having them sing (Evidence Grade = D). Keep eye contact, provide emotional support, and use soothing speech. Wash only what is necessary and keep actions very brief (Evidence Grade = D/A1).
- Use of towel or thermal baths reduced 14 types of agitated behaviors when compared to tub baths in one study. Marginal behavioral differences were noted in noisy breathing, facial grimacing, and negative vocalizations (Evidence Grade = D).

After the Bath

The process of bathing a person with dementia is many faceted. There are multiple issues going on at any one time for the caregiver to consider.

- Sometimes it is impossible to eliminate all negative behaviors, while other times, only a reduction in behaviors can be achieved. The caregiver needs to reevaluate the care situation moment to moment (Evidence Grade = A1). Documentation is critical for evaluating and planning additional bathing modifications (Evidence Grade = C1).
- When bathing is stressful, discussion and evaluation are required at report and care planning sessions. The healthcare team should "brainstorm" to explore every avenue for possible solutions to problems encountered while bathing (Evidence Grade = D).

Remember to celebrate small successes and share every little intervention with the team. It may mean the difference between the next caregiver providing a pleasant event or eliciting a catastrophic reaction from the individual (Evidence Grade = D).

Environmental Considerations

In attempting to manage negative behaviors associated with the bathing process, the actual room in which this activity occurs plays a major role in the outcome and plan of interventions. In older facilities the challenge is to make the bathing room a place that does not contribute to negative behaviors by alarming the individual who may interpret a large, sterile, cavernous room as threatening. How often do these rooms become the resting place of used or unused lifts, commodes, wheelchairs, linen hampers and supplies or boxes of personal items waiting for disposal? With a little creativity and planning even an older facility can have a home-like, pleasing environment for the person being bathed as well as for the person giving the bath.

Because of the frailties and physical limitations of individuals requiring care, the tubs and accompanying bathing equipment required for facilities do not resemble anything the person would remember from their past. However, much can be done so that this equipment does not become the focal point of the room. The following considerations can be used as a starting point in making any bathing room both functional and visually pleasing.

- Try to find another location for extra supplies/equipment which find their way into the space or if unable to relocate, hide it behind a screen or colorful curtain. Add extra cupboards if the area is large enough (Evidence Grade = D). A shelving unit with baskets for personal toiletries or bathing supplies is pleasing to the eye and adds interest and organization to the area (Evidence Grade = D).
- Look at the room from the other person's point of view. What is the first thing they see when entering the room? What do they see when they enter or leave the tub or the shower? Be creative with the bathing area: hang colorful posters or prints where they will get noticed; shelves decorated with items such as bottles, shells, ceramic fish are easy to install and do not need to be expensive. Add colorful towels hanging on decorative rods (Evidence Grade = D). Sew decorative towels in place if there is a possibility that someone may use them by mistake. Paint a large mural or ivy on the walls accented with hanging baskets of greenery or flowers (Evidence Grade = D).
- Lighting is important. It needs to be sufficient enough for the caregiver but also subdued enough not to startle the person being bathed. Lights shining off ceramic tiles cause a glare that is distressing to the person with dementia. Cove lighting is good for this area as it reflects toward the ceiling or wall sconces might be installed (Evidence Grade = D). Either way, have lights on dimmer switches so that they can be adjusted to individual needs (Evidence Grade = D).
- The hard surfaces of tiled walls and floors create echoes and can make any noise overwhelming. This is why it is important to limit the number of people coming in and out of the bathing area and remove excess equipment. Fabric will absorb sound. Use it generously for curtaining off bathing and showering areas and any windows in the room (Evidence Grade = D). Vinyl wallpaper in pretty patterns will also absorb sound and create visual interest. Add it to the top half of the area around the tub and surrounding walls. Water resistant acoustic panels can also cover walls as well as ceilings and can be made as decorative as desired (Evidence Grade = D).
- Eliminate offensive smells by making sure that soiled clothing is removed immediately. Clean hampers and floors where odor may linger with disinfectants regularly and thoroughly. Some odors can be masked by the use of scented sprays or electronic dispensers (Evidence Grade = D).
- Flooring needs to be examined from the aspects of cold and safety when wet. Floors should have a high coefficient of friction to be considered safe. Washable non-slip rugs are considerations if one is stepping out of tub or shower (Evidence Grade = D).

- Commercial towel warmers come in a variety of sizes. When choosing the appropriate size, consider the number needed if multiple baths are done in succession. Also consider if there is a need to have the larger bath blankets warming as well (Evidence Grade = D).
- Stable grab bars are of prime importance where individuals who require assistance are moving into tub or shower. It is important that they be very visible and strategically placed for safety (Evidence Grade = D).
- Wet skin feels cold and therefore the room needs to be maintained at a higher temperature than other areas the individual may frequent. Some bathing rooms, because of the manner in which the facility was constructed, may not have separate controls for adjusting the heat. A heat lamp on a timer or radiant heat panels can usually be permanently mounted to any room to supply an extra source of heat (Evidence Grade = D).
- Hand held showers are easier to control and more versatile than wall mounted. They can usually be attached to a bracket to use in the traditional way if the person is more independent (Evidence Grade = D).
- A seating area with a vanity can be both a focal point and a "finishing" spot. A table with a makeup mirror can be set up off the bathing area and will add to the hominess of the room as well as serve to help individuals complete their appearance after the bath (Evidence Grade = D).
- Tubs come in a wide variety of types in relation to their specific functions. Side entry, end entry, and those requiring specialized lifts are all available with a range of other functions such as water capacity, pre-fill features, manual versus digital controls, disinfecting systems, sitting or recumbent styles and whirlpool systems. How the individual with dementia enters the tub is the most important consideration when choosing a tub. Those systems where the person has to be raised a considerable height were shown to cause the largest degree of negative behaviors (Evidence Grade = C1).

Administrative/Systems Concerns

- An educational video containing research-based person-centered showering and towel bath techniques to reduce agitated behaviors in persons with Alzheimer's Disease were mailed (at no charge) to 15,453 nursing homes (NH) listed in the Centers for Medicare and Medicaid Services (CMS) database.
- Facilities that used the training materials reported high ratings for quality and effectiveness. An evaluation of training materials completed by participants resulted in 95% of nurses, 94% of nursing assistants, and 92% of administrators agreeing or agreeing strongly that the materials achieved the program's goals. Short-term outcomes of increased knowledge were achieved as demonstrated by an overall mean for participants' (nurses, nursing assistants, and administrators) test scores of 93% (Evidence Grade = B2).
- Nurses and administrators need to find methods to respect the wishes of PWD when actions do not threaten. PWD continue to tell caregivers what they want even when their verbal abilities decline (Evidence Grade = C1).

Definitions:

Scheme for Grading the Strength & Consistency of Evidence in the Guideline

A1 = Evidence from well-designed meta-analysis or well-done systematic review with results that consistently support a specific action (e.g., assessment), intervention or treatment

A2 = Evidence from one or more randomized controlled trials with consistent results

B1 = Evidence from high quality evidence-based practice guideline

B2 = Evidence from quasi experimental trials with consistent results

C1 = Evidence from observational studies with consistent results (e.g., correlational, descriptive studies)

C2 = Evidence from observational studies or controlled trials with inconsistent results

D = Evidence from expert opinion, multiple case reports, or national consensus reports

Clinical Algorithm(s)

A "Bathing Option Decision Tree" algorithm is provided in Appendix A and in the Quick Reference Guide of the original guideline document.

Scope

Disease/Condition(s)

Dementia

Guideline Category

Evaluation

Management

Prevention

Risk Assessment

Clinical Specialty

Family Practice

Geriatrics

Neurology

Nursing

Psychiatry

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Nurses

Occupational Therapists

Physician Assistants

Physicians

Guideline Objective(s)

To update the original University of Iowa guideline by reviewing current research, syntheses of research, and publications on bathing and dementia

Target Population

Patients with Alzheimer's disease or non-Alzheimer's dementia who require bathing assistance, especially in the setting of long-term care facilities

Interventions and Practices Considered

Evaluation

1. History and physical exam
2. Formal assessment for functional status

- Barthel's Index
 - Index of activities of daily living (ADL)
 - Asking direct caregivers if there are any issues with bathing such as resistance or agitation
3. Formal assessment for cognitive status
 - The Mini Mental State Examination (MMSE)
 - Clock Drawing
 - The Montreal Cognitive Assessment (MOCA)
 4. Behavioral assessment through observing and recording the person's response in certain situations and use of the patient record for a historical perspective of behaviors

Management

1. Establishing bathing methods using results of the above tests and assessments and discussing current preferences with patient/family
2. Documentation of the established method of bathing for caregivers to follow

Major Outcomes Considered

- Effectiveness of physical function, cognitive, and behavioral assessment tools in providing useful information
- Frequency and severity of negative bathing episodes
- Causes of negative bathing episodes
- Effectiveness of interventions to prevent negative bathing episodes

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Databases

Searches were performed using data bases available at the Banner Healthcare Libraries: Ovid Online: Medline R without revisions from 1996 to May, week 4, 2011. Five searches were conducted between August 15, 2010 until June 4, 2011. The Cumulative Index to Nursing and Allied Health Literature (CINAHL) data base was unavailable at this site. The initial search retrieved 115 references which were reviewed by the authors and 31 articles selected. Subsequent searches resulted in 958 total titles reviewed, 699 were selected for review of the abstract. Articles selected from subsequent Medline searches resulted in the use of 46 articles and book chapters. Additional articles and resources were generated by contacting authors of journal articles on Alzheimer's disease/dementia and bathing, yielding 7 additional for a total of 54 references.

Google searches were completed for the definition of bathing and Practice Guidelines for the topics: "Alzheimer's Practice Guidelines," "Bathing Practice Guidelines," and "Dementia Practice Guidelines." This yielded two practice guidelines used in the development of this guideline. Google searches were also conducted to find assessment instruments including the Katz Activities of Daily Living (ADL), the Mini-Mental Status Examination, the Barthel's Index, and the Montreal Cognitive Assessment. Google was also used to find the sites for the film and book: *Bathing Without a Battle*.

In evaluating current evidence it was determined that new studies were based on earlier resources on techniques. It was determined that not including the primary older resources would have been less instructive than including them, therefore all new research material has been highlighted in boxes marked "Key Points" in the original guideline document. Other older references refer to "Gold Standards" in clinical practice, such as the assessment instruments.

Keywords

The following search terms were used: Alzheimer's disease, dementia, functional assessment, cognitive assessment, bathing, self-care, nursing home, assisted living, and hygiene.

Inclusion and Exclusion Criteria

The database searches were limited to those that discussed bathing in dementia or were related to personal care in dementia or Alzheimer's disease. All searches were limited to studies of human subjects and were published in English. There were four studies included from outside the United States and Canada: three from Japan and one from Taiwan. Epidemiologic studies of large community-based populations were eliminated due to a lack of clinical relevance. Because of the bulk of data, two articles were omitted due to sites not well studied (home and hospital).

Number of Source Documents

A total of 54 references were used.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Scheme for Grading the Strength & Consistency of Evidence in the Guideline

A1 = Evidence from well-designed meta-analysis or well-done systematic review with results that consistently support a specific action (e.g., assessment), intervention, or treatment

A2 = Evidence from one or more randomized controlled trials with consistent results

B1 = Evidence from high quality evidence-based practice guideline

B2 = Evidence from quasi experimental trials with consistent results

C1 = Evidence from observational studies with consistent results (e.g., correlational, descriptive studies)

C2 = Evidence from observational studies or controlled trials with inconsistent results

D = Evidence from expert opinion, multiple case reports, or national consensus reports

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

The practice recommendations are assigned an evidence grade based upon the type and strength of evidence from research and other literature. The grading schema used to make recommendations in this evidence-based practice guideline is available in the "Rating Scheme for the Strength of Evidence" field.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

This guideline was developed from an exhaustive literature review and synthesis of current evidence on assessing heart failure in long-term care facilities. Research and other evidence, such as guidelines and standards from professional organizations, were critiqued, analyzed, and used as supporting evidence.

Articles were shared and reviewed by the three authors independently and consensus achieved.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Internal review, completed by the Hartford Center of Geriatric Nursing Excellence, included seeking feedback from two external expert content reviewers (see Contact Resources page in the original guideline document). Assessments were selected based upon use in clinical practice as a "gold standard," and were included in other practice guidelines. This guideline was reviewed by experts knowledgeable of research on bathing in dementia/Alzheimer's disease and development of guidelines. The reviewers suggested additional evidence for selected actions, inclusion of some additional practice recommendations, and changes in the guideline presentation to enhance its clinical utility.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for selected recommendations (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Decreased frequency and severity of negative bathing episodes in patients with dementia

Potential Harms

Not stated

Implementation of the Guideline

Description of Implementation Strategy

The "Evaluation of Process and Outcomes" section and the appendices of the original document contain a complete description of implementation strategies.

Implementation Tools

Audit Criteria/Indicators

Chart Documentation/Checklists/Forms

Clinical Algorithm

Quick Reference Guides/Physician Guides

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

End of Life Care

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Safety

Identifying Information and Availability

Bibliographic Source(s)

Hall GR, Gallagher M, Hoffmann-Snyder C. Bathing persons with dementia. Iowa City (IA): University of Iowa College of Nursing, John A. Hartford Foundation Center of Geriatric Nursing Excellence; 2013. 58 p. [51 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1996 (revised 2013)

Guideline Developer(s)

University of Iowa College of Nursing, John A. Hartford Foundation Center of Geriatric Nursing Excellence - Academic Institution

Source(s) of Funding

University of Iowa College of Nursing, John A. Hartford Foundation Center of Geriatric Nursing Excellence

Guideline Committee

Not stated

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Thiru-Chelvam B. Bathing persons with dementia. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2004. 37 p.

Guideline Availability

Electronic copies: Available for purchase on CD-ROM through [The University of Iowa College of Nursing's John A. Hartford Center for Geriatric Excellence Web site](#) .

Print copies: Available for purchase through [The University of Iowa College of Nursing's John A. Hartford Center for Geriatric Excellence Web site](#) .

Availability of Companion Documents

The following is available:

- Bathing persons with dementia. Quick reference guide. Iowa City (IA): University of Iowa College of Nursing, John A. Hartford Foundation Center of Geriatric Nursing Excellence; 2013.

The quick reference guide accompanies the full-text guideline and is available from the University of Iowa College of Nursing, John A. Hartford Foundation Center of Geriatric Nursing Excellence, 4118 Westlawn, Iowa City, IA 52242. For more information, please see the [University of](#)

The original guideline document includes a variety of implementation tools, including helpful communication techniques, the Procedure for Thermal Bathing Method, a towel or bed bath methods, the Bathing Knowledge Assessment Test, process indicators (Process Evaluation Monitor), and outcome indicators (Bathing Persons with Dementia Outcomes Monitor).

Patient Resources

None available

NGC Status

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